STATE OF CONNECTICUT

OFFICE OF PROTECTION AND ADVOCACY FOR
PERSONS WITH DISABILITIES
60B WESTON STREET, HARTFORD, CT 06120-1551

JAMES D. McGAUGHEY
Executive Director

Phone: 1/860-297-4307
Confidential Fax: 1/860-297-4305

Testimony of the Office of Protection and Advocacy for Persons with Disabilities

Before the Select Committee on Children

Submitted by: James D. McGaughey

Executive Director

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Good morning and thank you for this opportunity to comment on Proposed Bill No. 198, An Act Concerning Riverview Hospital. The bill proposes to close Riverview and relocate its patients to private facilities. I apologize for not being at today's hearing, but I am unable to attend due to another commitment.

For the past several years, our Office has conducted a project involving the young people living in four of the units at Riverview. We began the project after investigating reports of serious injuries sustained by children while being restrained and secluded at the hospital. Our investigation led us to interview the children, as well as to review their treatment programs and the general programming options available to them at the hospital. We determined that many of the incidents that led to use of restraint and seclusion could have been avoided, and that the children themselves often were able, with some active listening and guidance, to articulate options that would have worked better for them and for their staff. We then worked with groups of those children to teach and encourage them to advocate for their own needs and rights in the hospital setting. I believe these efforts have been worthwhile, but the fundamental dynamics that led us to become involved in the first place – over-reliance on restraint and seclusion – have proven difficult to address. There is a perception on the part of the staff that at least some of their clients "need that" – a perception that is difficult, and some would say is impossible to overcome, especially as the facility has been subjected to considerable scrutiny and criticism in recent years and staff has grown defensive.

Given this experience, one might expect that our Office would enthusiastically support the proposal to close Riverview and transfer its clients to privately operated intensive programs. However, we have also been receiving reports of serious injuries resulting from restraint use in

privately operated children's psychiatric residential treatment facilities. In fact, we recently concluded an investigation into restraint-related injuries in one private provider's programs. Our findings, which we have brought to DCF's attention, indicate that those programs also over-rely on restraint and seclusion – practices that have led to serious injuries to some of the children they serve and, in at least one case, caused a child to lose consciousness for approximately ten minutes before he could be revived. Just as we had observed at Riverview, we found that children in that private facility were not well understood as individuals, and that treatment practices tended to be driven more by the program's culture and perceived need to maintain control than by the individual needs of the children who are its clients.

Neither the Riverview staff nor those employed by the private provider are bad people. When interviewed, staff in both facilities evidenced genuine concern for their clients, and clearly regretted the injuries they had sustained. Nonetheless, they really couldn't see how their own actions (or inactions) might have contributed to their clients' escalating behaviors, and they were largely unaware of the extent to which positive behavioral approaches could, if skillfully implemented, help those clients to learn more adaptive approaches to interacting with others. The private provider's staff did indicate that if there were more resources available in their program to hire more workers, they would be able to pay more attention to individuals who are having a tough time. They also indicated they would welcome more training in positive behavioral support techniques and opportunities to work with experienced consultants – things that could benefit all involved. However, neither the programs' designs nor the practices actually being employed in either facility reflected the kind of organizational beliefs and expectations that are conducive to successfully eliminating reliance on restraint and seclusion, and implementing positive behavioral support technologies.

Part of the problem in deciding what to do about Riverview is that in Connecticut, as in most other states, the children's mental health system is in crisis. In fact, it is all about crisis. If a child begins to experience serious mental health problems, it will take two, three, or four months before that child can be seen by a child psychiatrists in private practice – even if the parents have good health insurance. If things become acute, the family is told to bring the child to an emergency room for evaluation. From there he or she may be admitted to an inpatient unit somewhere – often not at the same hospital, in fact sometimes to a hospital that is a considerable distance from home. If no beds are available, the child stays in the emergency department. Because hospitals were complaining about the children being inappropriate kept on hold in emergency departments, and insurers and other funders were complaining about the costs, we developed mobile crisis teams and various outpatient programs that are geared to averting hospital admissions. Sometimes they do, sometimes they do not. But the goal of all these interventions – mobile crisis teams, intensive outpatient programs and even inpatient hospitalization – is to quickly "stabilize" the child's symptoms and then refer that child and his or her family to a less costly source of out-patient counseling, which is usually coupled with occasional 15 minute "med checks" by the clinic's psychiatrist. There is very little attention paid

to ensuring continuity in treatment approaches between the crisis intervention services and counseling service, much less any recognition of the importance of ensuring communication and coordination with schools, medical providers and other community support organizations that touch the child. And, there is virtually no thought given to articulating a goal of genuine mental health – real wellness and recovery.

It is little wonder, then, that so many kids – and their families - cycle in and out of crisis, and that some of those kids experience a big enough crisis, or present enough additional complexity to win admission to the highest level of care available - hospital level residential services. The irony is that even if a child truly has the types of needs that warrant that highest level of intervention, he or she will still likely be met with a mediocre therapeutic response, while being exposed to traumatizing and potentially dangerous restraint and seclusion practices.

Connecticut should not close Riverview simply to save money, and we should definitely not transfer its clients to private hospital-level services until we have invested sufficient human and financial resources to ensure those privately operated programs are capable of achieving truly good outcomes. In the long run, however, it would better serve our children to invest whatever might be saved by closing Riverview in an effort to more adequately fund integrated systems of care that can work with a child's school, and other community institutions and agencies to support long term recovery.

Thank you for your consideration of these comments. I will be happy to respond to any questions.